Women in Medicine: Myths and Realities

WOMEN CONSTITUTE 54 percent of the population of the United States, yet they make up only 11 percent of the physician population. In the 130 years since Elizabeth Blackwell became the first woman to graduate from a medical school in this country, little progress was made in redressing this inequity until the 1970's. Since 1970, the percentage of female students has increased from 9.6 percent to 24 percent. However, myths persist about women physicians which may inhibit the continued growth in the number of women in medicine. Some of these myths are discussed below.

Women physicians are less productive than men physicians. Studies in the 1950's and early 1960's indicated that women physicians practiced 40 percent fewer hours than men. Recent data indicate that women physicians work 90 percent of the hours practiced by their male colleagues. The time out of medicine is the equivalent of slightly less than 12 months and is accounted for almost entirely by childbearing and childrearing responsibilities. Interestingly, none of these studies took into account the fact that women physicians have a working life expectancy that exceeds that of men physicians by a year and a life expectancy that exceeds that of men physicians by five full years.

Women physicians are less satisfied with medicine than men physicians. The available data suggest that despite some restrictions in choice of speciality, women are as satisfied with their medical careers as men.

A career in medicine is "unhealthy" for women. When compared with the US female population, women physicians have a lower mortality in every age group. This is especially true for women physicians in California, for whom actual deaths are found to be 91.9 percent of expected deaths.

It is difficult for a woman to get into medical school. Women are accepted into medical school in direct proportion to the number of women applicants. In the past ten years there has been no evidence that admissions committees nationwide underselect women. There are some instances where overselection, in terms of numbers, is evident.

Women in medicine have more psychopathologic problems than men. While the data in this area are sparse they indicate that women physicians appear to require admittance to psychiatric hospitals less frequently (but for the same types of problems) than men. Being a physician and a mother was not a factor in the cause of the problems precipitating admittance to psychiatric hospital. The incidence of suicide for women physicians and women medical students is three to four times greater than that for their nonphysician peers but is almost exactly the same as for their male colleagues in medicine.

Clearly, not all barriers to being a women physician have been eliminated. Unique but very real problems remain for women who choose to practice medicine.

Women continue to experience prejudice and barriers in the choice of speciality. Women medical students report that surgery and surgical subspecialities and, in some cases, obstetrics-gynecology are the areas that reflect the greatest prejudice against their entry. Women are substantially under-represented in the surgical specialities and over-represented in pediatrics and psychiatry.

Being a physician, wife and mother is extraordinarily demanding. These demands are felt in a variety of ways. Women physicians have a 48 percent higher divorce rate than men physicians. Women physicians are considerably more likely to remain single (31 percent versus 2 percent). When they do marry, they will have fewer (2.5) children than the spouses (3.2) of their male colleagues. Also, they are more likely to marry another physician (36 percent) than their male peers (2 percent). The triple role of physician, wife and mother is extraordinarily demanding in time and energy, and women physicians feel even more *pushed* and *pulled* than do men physicians.

Patients have stereotyped views of physicians. Patients in the United States have sex-typed views of medical roles and 96 percent report that the typical physician is a man. Seventy-eight percent of patients prefer men physicians and view women physicians as less competent and less experienced. This prejudicial stereotype breaks down when the patients have had experience with a woman physician. Thus, as the number of women in medicine increases, this problem will diminish. The most negative attitudes were voiced by Span-

ish speaking patients while the most positive attitudes were expressed by black women and obstetric patients.

Myths serve to dissuade young women from choosing medicine as a career more than do the actual problems indicated above. Practical solutions exist for dealing with the latter. Sex stereotypes are slowly losing their influence as awareness of sexism increases. As more patients are treated by women physicians, patients and physicians alike will come to accept women physicians as major assets in medicine.

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Incest

INCEST OR intrafamilial sexual abuse involving a child and a parent or parent figure may involve as many as 2 to 3 children per 1,000 families in the United States. Intrafamilial sexual abuse of a child is the most easily concealed, least publicized and most distressful form of child abuse and may be more common than physical abuse. Most cases reported involve a female child and a male parent or parent figure.

Sexual abuse of a child by a family member often disrupts the whole family; therefore, many cases are overlooked or ignored by professionals eager to avoid such agitation. As a result many girls who do report intrafamilial sexual abuse are viewed with suspicion and sometimes even hostility. The report is often considered a lie or a fantasy. However, children do not fabricate stories of detailed sexual activities unless they have witnessed them, and every report needs to be investigated thoroughly.

In some instances a child's report of sexual abuse by a family member is verified, but the professional involved fails to intervene on her behalf because of a belief that the child is seductive and, therefore, in some way responsible for the abuse. This attitude reflects a prejudice against child victims of sexual abuse and diminishes the concept that the adult is primarily responsible for his behavior and for initiating a sexual relationship with a highly vulnerable, developmentally immature child incapable of giving informed consent to such a relationship.

Incest and other intrafamilial sexual abuse involving a child is covered by mandatory child abuse reporting laws in most states, and physicians as well as all other health care professionals are required to report known or suspected cases. Early identification and intervention on behalf of the child may prevent long-term emotional damage and help to break the intergenerational chain of intrafamilial sexual abuse.

Vital to the process of early identification and intervention is the recognition of high-risk populations as well as physical and behavioral indicators. Incest and intrafamilial sexual abuse of a child differs from rape in that (1) the sexual abuse usually takes place over years rather than in a single incident, (2) the victim is emotionally and physically dependent on the abuser and, therefore, may be ambivalent about initiating a report, and (3) there is *covert* permission given for the abuse by other family members (particularly the mother) by their lack of effective intervention on the child's behalf.

Because of the nature of intrafamilial sexual abuse there is often no clear physical evidence of the abuse. However, there are some physical indicators which should alert physicians to consider the possibility that sexual abuse may be taking place: (1) Genital injuries such as tearing, inflammation or bruising, especially when the bruises occur around the vagina or buttocks and the injury is more severe internally than externally; (2) venereal disease of the eyes, mouth, anus or genitalia of a young child; (3) evidence of semen (oral, rectal, vaginal); (4) repeated or unexplained vaginal infections; (5) genital warts when there is no believable explanation as to the cause; (6) pregnancy in young girls when the child and the family offer a reluctant or unlikely explanation of her partner; (7) pregnancy in young girls when the family refuses to acknowledge the pregnancy or to obtain proper prenatal care for the child, and